

**Intent to Apply for Institutional Accreditation**

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| **Sponsoring Institution***(The entity that has ultimate responsibility for ACGME-accredited programs)* |
| **Name of Sponsoring Institution**:       |
| **Address**:       |
| **City, State, ZIP code**:       |
| **Sponsor Website Address**:       |
| **Designated Institutional Official (DIO) Information***(The individual who has the authority and responsibility for all of the ACGME-accredited graduate medical education programs at this institution)* |
| **Salutation**:       | **First Name**:       | **Middle**:       | **Last**:       |
| **Degree(s)**:       | **Email**:       |
| **Mailing Address**:       | **Phone**:       |
| **Fax**:       |
| **Ownership/Control and Type of Institution**(*Address the type of institution being applied for as well as the specifics of its oversight*) |
| **Ownership or Control Type** (*select one*):*See* [*Data Dictionary for Sponsoring Institution and Participating Site Ownership/Control Types*](https://acgmehelp.acgme.org/hc/en-us/articles/14071500332567-Data-Dictionary-for-Sponsoring-Institution-and-Participating-Site-Ownership-Control-Types) *for definitions* |
| [ ]  Government, Federal:  | [ ]  Tribal Governance |
| [ ]  Government, Non-Federal:  | [ ]  Non-Government, Not-for-Profit:  |
| [ ]  Investor-Owned, For-Profit:  | [ ]  Physician-Owned, Not Incorporated |
| **Type of Institution** (*select one*):*See* [*Data Dictionary for Sponsoring Institution and Participating Site Types*](https://acgmehelp.acgme.org/hc/en-us/articles/14071444045079-Data-Dictionary-for-Sponsoring-Institution-and-Participating-Site-Types) *for definitions* |
| [ ]  Ambulatory Care/Community Health Center | [ ]  Ambulatory Care/Other: *If Other, please specify:*       | [ ]  Ambulatory Surgery Center |
| [ ]  Consortium | [ ]  End-of-Life Care Facility (Hospice) | [ ]  General Hospital |
| [ ]  Governmental Public Health Agency | [ ]  Health System | [ ]  Long-Term Care Facility |
| [ ]  Medical Examiner’s Office | [ ]  Medical School | [ ]  Military Treatment Facility:  |
| [ ]  Non-Medical School Educational Foundation/Organization | [ ]  Poison Control Center | [ ]  Prison/Jail/Other Carceral Facility |
| [ ]  School (Primary/Secondary/College/University) | [ ]  School of Public Health | [ ]  Specialty Hospital: *If Other, please specify:*       |
| [ ]  Sports Venue | [ ]  VA Healthcare System Facility:  | [ ]  Blood Collection and Processing Center |
| [ ]  Reference Laboratory | [ ]  Other (please specify):       |
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| For how many programs does the Sponsoring Institution plan to apply for accreditation? |       |
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| **I recognize this form is not an application for ACGME institutional accreditation, but a means to indicate intent to begin the application process for institutional accreditation.** DIO Signature: Date:        |

Email this completed form to ADS@acgme.org. Once it has been received and processed, the DIO will be emailed a username and password to access the Accreditation Data System (ADS) to complete the application for institutional accreditation.